

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

836 11540

Reg. Dist. No. 253

1. PLACE OF DEATH:

County Queen Anne Co.City or town Stevensville (Rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Entire Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen AnneCity or town Stevensville (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James Sudler Cockey

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Married</u>

6.(b) Name of husband or wife Mary Ringold Cockey

7. Birth date of deceased (mo., day, yr.)	6.(c) If alive, give age
<u>Dec. 21, 1866</u>	<u>80</u> years

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>11</u>	<u>11</u>hrs.min.

9. Birthplace Stevensville-Queen Anne Co., Md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name James Edward Cockey13. Birthplace Kent Island, Md.14. Maiden name Frances Anne Downs15. Birthplace Kent Island, Md.16. Informant Sudler CockeyAddress Stevensville, Md.17. Burial Date thereof Dec. 3, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory StevensvilleLocation Stevensville, Maryland18. Funeral director Maurice E. Newnam & SonAddress Easton, Maryland19. Dec. 2 1947 Elizabeth Carter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1947 at 4 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1947 to Dec. 1 1947 and that I last saw him alive on Dec. 1 1947.

Immediate cause of death

Arteriosclerosis (general)
Cerebral thrombosis
Cerebral malaria
Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodor Sattelmeier MDAddress Stevensville Date signed 12/2/47

DURATION

Several
yearsMay 16-1947Several
years

RECEIVED

DEC 6 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Joyce Ann Dixon

3. (b) Social Security Number

none

4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Oct. 24-1942 6.(c) If alive, give age _____ years

8. AGE: Years 5 Months 1 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Centerville, Md.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business _____

12. Name John Dixon

13. Birthplace Centerville Maryland

14. Maiden name Bartholomew

15. Birthplace Centerville Maryland

16. Informant Bartholomew E. Dixon

Address Centerville Maryland

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Dec. 11-47
 (month) (day) (year)

Cemetery or crematory Christiansburg

Location Centerville Maryland

18. Funeral director Barton Bros

Address Centerville Maryland

19. 12-10-47 Elie Ametroug
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1947 at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1946 to Dec 10 1947
 and that I last saw him alive on Dec 10 1947

Immediate cause of death _____ DURATION
Pulmonary E. coli infection few weeks
 Due to Chronic E. coli infection
depression with acute infection 3 years
 Due to infection
Chronic active fever 3 years
 Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

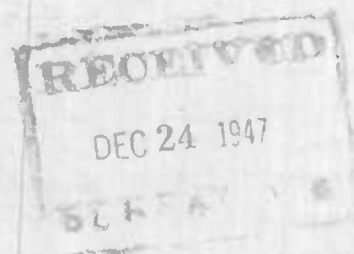
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE C. P. Ray, MD

Address Centerville Md M. D. or other

Date signed 12-10-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202251

1. PLACE OF DEATH:

County Prince George'sCity or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 1/2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Paul Burkhead

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of

deceased (mo., day, yr.)

Sept 7, 1947

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

3 27 _____ hrs. _____ min.

9. Birthplace

Chesapeake

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

12. Name

Paul Burkhead

13. Birthplace

Chesapeake

14. Maiden name

Batchelor

15. Birthplace

Chesapeake

16. Informant

Paul Burkhead

Address

Chesapeake

17. (Burial, cremation, or removal, which?)

Cremation

Date thereof

Dec. 26, 1947

(month) (day) (year)

Cemetery or crematory

Crematorium

Location

Chesapeake

18. Funeral director

William J. Bowers

Address

Wilmington

19. (Date rec'd by registrar)

Dec. 24, 1947

Registrar

Clara L. Barnes

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1947 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Dec 24, 1947Immediate cause of death Respiratory med. 24 dec.

DURATION

ProbableDue to Broncho pneumonia

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____Where did injury occur? None

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury None Injured at work? _____Signature Paul Burkhead

M. D. or other

Address ChesapeakeDate signed Dec 24/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITALS
CERTIFICATE OF MARRIAGE

RECEIVED
DEC 29 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 11543
 Reg. Dist. No. 251

1. PLACE OF DEATH: Queen Anne's
 County Rural
 City or town Pondtown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Queen Anne's
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Annie E. Elliott

3. (b) Social Security Number none

4. Sex Female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Samuel H.

7. Birth date of deceased (mo., day, yr.) Jan. 7 1882 6.(c) If alive, give age 65 years

8. AGE: Years About 65 Months 7 Days 10 It less than one day 10 min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Davis

13. Birthplace Md.

14. Maiden name unknown

15. Birthplace unknown

16. Informant Samuel H. Elliott

Address Rural
Chesbourn Md.

17. (Burial, cremation, or reinterment, which) Burial Date thereof Dec 10 1947
 (month) (day) (year)

Cemetery or crematory St. Pheasant
Clng.

Location Pondtown
Md.

18. Funeral director Edward Holloway
 Address Willington Md.

19. Dec. 6 19 47 Edgar L. Lane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH December 5 19 47 at 12 P. M.

21. I CERTIFY that death occurred on the date above stated; that the decedent died from acute myocardial infarction
 and that I last saw h. alive on Sept 15 19 47

Immediate cause of death Myocardial infarction

Due to Myocardial infarction

Due to Myocardial infarction

Other conditions ✓

(Include pregnancy within 2 months of death)

Major findings of operations ✓

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ✓ Date of Dec 5 1947

Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, or public place (where?) ✓

Means of injury ✓ Injured at work?

23. SIGNATURE Edward S. Dredger
Chesbourn Md.

Address Chesbourn Md. Date signed Dec 6

RECORDED

DEC 9 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Stamp every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH: County..... <u>New Anne</u> City or town..... <u>Centerville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>all his life</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>New Anne</u> City or town..... <u>Centerville</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war..... <input checked="" type="checkbox"/>			
3. (a) FULL NAME <u>Joseph Whiting Oymon</u>				3. (b) Social Security Number <u>none</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Married</u>			
6.(b) Name of husband or wife <u>Minnie Thomas Oymon</u>				6.(c) If alive, give age <u>74</u> years			
7. Birth date of deceased (mo., day, yr.) <u>June 29 - 1868</u>				8. AGE: Years <u>79</u> Months <u>5</u> Days <u>14</u> If less than one dayhrs.min.			
9. Birthplace <u>Centerville, Md.</u> (Town, county, and state)				10. Usual occupation <u>Merchandise & Freight</u>			
11. Industry or business <u>John W. Oymon</u>				12. Name <u>John W. Oymon</u>			
13. Birthplace <u>Chestertown, Md.</u>				14. Maiden name <u>Mary Jackson Whiting</u>			
15. Birthplace <u>Caracas - Venezuela</u>				16. Informant <u>John W. Oymon</u>			
Address <u>Myflower Apts - Fleming L.D. Barrie</u>				17. (Burial, cremation, or removal, which?) <u>See 16/47</u>			
Cemetery or crematory <u>Chestertown</u>				Location <u>Centerville, Md.</u>			
18. Funeral director <u>Barton Bros</u>				Address <u>Centerville, Md.</u>			
19. (Date rec'd by registrar) <u>Dec. 16 - 1947</u>				Registrar <u>Elis L. ...</u>			

MEDICAL CERTIFICATION	
2D. DATE OF DEATH <u>Dec 13 - 1947</u> at <u>6:30 P.</u> M	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan 1 - 1947</u> to <u>Dec 13 - 1947</u> and that I last saw him alive on <u>Dec 13 - 1947</u>
Immediate cause of death <u>Angina Pectoris</u>	DURATION <u>1 yr</u>
Due to	Other conditions
(Include pregnancy within 3 months of death)	
Major findings of operations	
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide	Date of
Where did injury occur?	(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)	Means of injury
Injured at work?	Signature <u>W. Henry Fisher</u>
23. SIGNATURE <u>Centerville Md.</u>	M. D. or other <u>12/15-47</u>
Address	Date signed

RECEIVED
DEC 24 1947
SEA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11545

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne's
 City or town Centerville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about 1 month
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne's
 City or town Brownsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Samuel Parks

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 30 - 1885

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

62629

hrs.

min.

9. Birthplace

Brownsville 20 Co. Md
(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

MOTHER FATHER

12. Name

Thomas B. Parks

13. Birthplace

Tammant Somerset Co Md

14. Maiden name

Elizabeth Brown

15. Birthplace

Brownsville, Maryland

16. Informant

Mrs Edmund Nelson

Address

Centerville Maryland

17.

(Burial, cremation, or removal. Which)

Date thereof

Dec 31 - 47
(month) (day) (year)

Cemetary or crematory

Chesapeake

Location

Centerville Maryland

18. Funeral director

Barton Bros

Address

Centerville Maryland

19.

(Date rec'd by registrar)

Dec 31 - 47Elie Armstrong

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1947, at 2:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1947 to Dec 24 1947and that I last saw him alive on Dec 24 1947

Immediate cause of death

Carcinoma of Rectum

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

H. Mathews
Address Centerville Md Date signed 12/30/47

RECEIVED

JAN 5 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen Anne's
 City or town Sudlersville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 yrs
 Hospital, institution, or street address where death occurred:
none
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Queen Anne's
 City or town Sudlersville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Virginia H Price

3. (b) Social Security Number

4. Sex Female 5. Color of race Colored 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife John E Price
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 10 1881
 8. AGE: Years 66 Months 7 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Md. (Town, county, and state)
 10. Usual occupation House Wk.
 11. Industry or business _____
 12. Name John Hockett
 13. Birthplace Md.
 14. Maiden name Virginia Hockett
 15. Birthplace Md.

16. Informant John E. Price
 Address Sudlersville, Md.
 17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 31 1947
 (month) (day) (year)
 Cemetery or crematory Price's Chapel
 Location Prices Chapel
 18. Funeral director Calvin Clark
 Address 102 S. Queen St, Dover, Del.
 19. 12-30 19 47 Edgar L. Lane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 19 47 at 6:30 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 47 to Dec 28 19 47
 and that I last saw her alive on Dec 28 19 47

Immediate cause of death Quite Prolonged Disturbance
 DURATION _____
 Due to Chronic Myocardial
Chronic Hypertension
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE @11/11/11/11 M. D. or other _____
 Address Sudlersville, Md. Date signed 12/29/47

JAN 12 1948

JAN 13 1948

THE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

11547
83a
Reg. Dist. No. 251

1. PLACE OF DEATH:

County 99 The Washington
City or town Adams
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind. County Green Acres
City or town Rural Millington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

James O'Neill Rolph

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Katherine V. Rolph

7. Birth date of deceased (mo., day, yr.) Jan 1 1863 6. (c) If alive, give age 84 years

8. AGE: Years 84 Months Days If less than one day
hrs. min.

9. Birthplace Ind.
(Town, county, and state)

10. Usual occupation Railroad Conductor

11. Industry or business

12. Name James O'Neill Rolph

13. Birthplace Ind.

14. Maiden name Unknown

15. Birthplace

16. Informant Mike Fimple

Address Washington Del

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec. 4-47
(month) (day) (year)

Cemetery or crematory Marshall's Farm

Location near Church Hill Ind.

18. Funeral director Edgar D. Kane

Address Church Hill Ind.

19. Dec 4 19 47 Edgar D. Kane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 19 47 at 11:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 19 47 to Dec 1 19 47
and that I last saw him alive on Nov 26 19 47

Immediate cause of death Cerebral Hemorrhage

Due to Cerebral Arterial Sclerosis

Due to Senility

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. D. Fimple M. D. or other

Address Frederick, Ind. Date signed 12/4/47

CERTIFICATE OF DEATH

State of Massachusetts, County of Suffolk

On the 9th day of December, 1947, at Boston, Massachusetts, I, the undersigned, Registrar of Vital Records, do hereby certify that the within and foregoing is a true and correct copy of the original record of death as the same appears in the files of the Registrar of Vital Records.

In testimony whereof, I have hereunto set my hand and the seal of the Department of Health at the City of Boston, this 9th day of December, 1947.

REGISTRAR OF VITAL RECORDS

JOHN J. HARRIS

By _____

General Registrar

(Signature)

RECORDED
DEC 9 1947
BOSTON

With a copy of the death certificate
sent to the family of the deceased

General Registrar
Department of Health

12/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11548 251

1. PLACE OF DEATH

County Pr
City or town Crumpton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All life
Hospital, institution, or street address where death occurred: NO
How long in hospital or institution? NO

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind. County 9 a.
City or town Crumpton
(If outside city or town limits, write RURAL and give nearest town)
Street No. NO
(If rural, give LOCATION)
2.(a) If veteran, name war NO

3. (a) FULL NAME

Margaret Elizabeth Ryland
4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow

3. (b) Social Security Number

6.(b) Name of husband or wife David A. Ryland
6.(c) If alive, give age NO years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1864
8. AGE: Years 83 Months 2 Days NO If less than one day NO hrs. NO min. NO

9. Birthplace 999
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business David Sheats

MOTHER FATHER
12. Name David Sheats
13. Birthplace 999
14. Maiden name Woodall
15. Birthplace 999

16. Informant Miss Ethel Ryland
Address Crumpton Ind
17. Burial Date thereof Dec. 7-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Crumpton

Location Crumpton Ind
18. Funeral director Edgar A. Lane
Address Church Hill Ind

19. 12-7 19 47 Edgar A. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 19 47 at 6:00 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 19 47 to Dec 7 19 47
and that I last saw NO alive on Dec 6 19 47
Immediate cause of death Cerebral Hypertension
DURATION
Due to Cerebral Cerebral Polymy
Due to Chronic Myocarditis
Other conditions NO
(Include pregnancy within 3 months of death)

Major findings of operations NO Date of op. NO
Autopsy results NO
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide NO Date of NO
Where did injury occur? NO (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) NO
Means of injury NO Injured at work? NO

23. SIGNATURE C. M. Woodall M. D. or other
Address Princeton, Ind Date signed 12/7/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 12 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11549

1700

Reg. Dist. No. 254

1. PLACE OF DEATH:

County Queen Anne's
 City or town Prince Georges
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Smith

4. Sex

male

5. Color or race

Caucas

6. (a) Single, married, widowed, or divorced

don't know

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years
about 1900

8. AGE:

Years

Months

Days

If less than one day

about 47——

..... hrs. min.

9. Birthplace

South Carolina
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

don't know

13. Birthplace

"

14. Maiden name

"

15. Birthplace

"

16. Informant

Investigator of Deeper Cole

Address

Mr. State Police Centerville Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Dec 10 47
(month) (day) (year)

Cemetery or crematory

Chesterfield

Location

Centerville Maryland

18. Funeral director

Barton Bros

Address

Centerville Maryland

19. Dec. 11

(Date rec'd by registrar)

47Allen M. Aldridge
Registar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Marshall
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

don't know

3. (b) Social Security Number

231-09-2447

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1947 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death This man was hit by an auto on State Highway
Both legs were broken & hisDue to neck was broken

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/8-47Where did injury occur? Marshall (City or town) Md (County) (State)Injured at home, farm, industry, public place (where?) State HighwayMeans of injury Hit by auto Injured at work?23. SIGNATURE W. Henry FisherAddress Centerville Md Date signed 12/10-47

RECEIVED

DEC 16 1947

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11550 253

1. PLACE OF DEATH: *Queen Anne*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Margaret Stauch*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*
 6.(b) Name of husband or wife *Harry Stauch*
 6.(c) If alive, give age *64* years
 7. Birth date of deceased (mo., day, yr.) *Sept 21 - 1874*
 8. AGE: Years *73* Months *3* Days *6* If less than one day
hrs.min.

9. Birthplace *Tacket Co - Md*
 (Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business

12. Name *William Carey*

13. Birthplace *Tacket Co - Md.*

14. Maiden name *Sarah Lane*

15. Birthplace *Tacket Co - Md*

16. Informant *Harry Stauch*

Address *Chester - Md*

17. Burial (Burial, cremation, or removal. Which?) Date thereof *Dec 29/47*
 (month) (day) (year)

Cemetery or crematory *Stevensville Cemetery*

Location *Stevensville, Md*

18. Funeral director *Barton Bros*

Address *Centerville, Md*

19. *Dec 29 1947* Registrar

(Date rec'd by registrar) *Elizabeth Foster* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*December 27, 1947* at *9:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1947 to *December 1947*

and that I last saw *June* alive on *December 26, 1947*

Immediate cause of death.....

Arteriosclerotic Cardiovascular Disease

with Cardiac Decomposition

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE.....*William C. Lane*

M. D. or other *MD*

Address *Queenstown, Md.* Date signed *12-27-47*

RECEIVED

JAN 6 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11551

Reg. Dist. No. 251

1. PLACE OF DEATH: County <u>Brown Anne</u> City or town <u>Millington (Rural)</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>3 yrs.</u> Hospital, institution, or street address where death occurred: <u>Palmary Nursing Home</u> How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Talbot</u> City or town <u>Easton</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2(a) If veteran, name war _____	
3. (a) FULL NAME <u>Jennie B. Suhr</u>		3. (b) Social Security Number _____	
4. Sex <u>Female</u>	5. Color of skin <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Divorced</u>	
6. (b) Name of husband or wife _____			
6. (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>Aug. 19, 1863</u>			
8. AGE: <u>84</u>	Years <u>3</u>	Months <u>29</u>	Days If less than one day _____ hrs. _____ min.
9. Birthplace <u>Unknown</u> (Town, county, and state)			
10. Usual occupation <u>None</u>			
11. Industry or business _____			
MOTHER FATHER	12. Name <u>Fredrick J. Suhr</u>		
	13. Birthplace <u>Unknown</u>		
	14. Maiden name <u>Caroline E. - Unknown</u>		
MOTHER FATHER	15. Birthplace <u>Unknown</u>		
	16. Informant <u>Mrs. J. B. Sparritt</u> Address <u>Easton, Md.</u>		
17. Burial (Burial, cremation, or removal, Which?) <u>Dec. 23, 1947</u> (month) (day) (year) Cemetery or crematory <u>Spring Hill</u> Location <u>Easton, Md.</u>			
18. Funeral director <u>R. P. Peto Clark</u> Address <u>Easton, Md.</u>			
19. <u>12-20-47</u> 19 <u>47</u> <u>11-11-47</u> (Date rec'd by registrar) Registrar			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>Dec. 15</u> 19 <u>47</u> at <u>11:45</u> AM			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 10</u> 19 <u>47</u> to <u>Dec. 15</u> 19 <u>47</u> and that I last saw <u>her</u> alive on <u>Dec. 15</u> 19 <u>47</u>			
Immediate cause of death <u>Emphysema from stomach & blood</u>			
DURATION <u>24 hrs.</u>			
Due to _____			
Due to <u>Carcinoma of stomach</u>			
Other conditions _____			
(Include pregnancy within 3 months of death)			
Major findings of operations _____			
Autopsy results _____			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident, suicide, or homicide _____ Date of _____			
Where did injury occur? _____ (City or town) _____ (County) _____ (State)			
Injured at home, farm, industry, public place (where?) _____			
Means of injury _____ Injured at work? _____			
23. SIGNATURE <u>Wm. H. Peto</u> M. D. or other _____			
Address <u>Millington, Md.</u> Date signed <u>12/19/47</u>			

RECEIVED

JAN 10 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

11552

Reg. Dist. No. 251

1. PLACE OF DEATH

County..... Queen Annes
 City or town..... Rural Millington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex..... M 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Mammie Tracy

7. Birth date of deceased (mo., day, yr.)..... March 10 1887 6. (c) If alive, give age..... years

8. AGE: Years..... 60 Months..... 8 Days..... 25 It less than one day..... hrs..... min.....

9. Birthplace..... Crumpton Md.10. Usual occupation..... Farmer

11. Industry or business

12. Name..... Charles Tracy
 13. Birthplace..... Edwards

14. Maiden name..... Emma Harrison
 15. Birthplace..... Md.

16. Informant..... Mrs. Mammie Tracy (Wife)
 Address..... Rural Millington Md.

17. Buried Date thereof..... Dec. 9 1947
 (Burial, cremation, or removal where?) (month) (day) (year)

Cemetery or crematory..... Crumpton

Location..... Crumpton Md.
 18. Funeral director..... Edward Holloway
 Address..... Millington Md.

19. Dec. 6 19 47 Edgar D. Rone
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Md. County..... Queen Annes
 City or town..... Rural Millington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 5 19 47 at 2 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 19 47, to Dec. 5 19 47
 and that I last saw him alive on Dec. 4 19 47

Immediate cause of death..... Pneumonia
4 days

Due to..... Chronic Industrial InfectionDue to..... Pneumonia

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Wm. H. Smith

M. D. or other

Address..... Millington Date signed..... Dec. 6/47

REC-1000
DEC 9 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11553

Reg. Dist. No.

202251

1. PLACE OF DEATH:

County Queen Anne
 City or town Kingston
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 33 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne
 City or town Kingston
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. * Chestertown, Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Claude E. Truslow

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mildred Collins Truslow
living 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 22, 1887

8. AGE: Years 60 Months 6 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Long Island New York
 (Town, county, and state)

10. Usual occupation Poultry Industry

11. Industry or business

FATHER 12. Name WM. Hagadorn Truslow
 13. Birthplace New York

MOTHER 14. Maiden name Ella E. Sninch
 15. Birthplace New York

16. Informant Mrs. Mildred Truslow (wife)
 Address Chestertown, Md.

17. Burial Dec. 27, 1947
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Chester Cemetery
 Location Chestertown, Maryland

18. Funeral director J. Willis Wells
 Address Chestertown, Md.

19. Dec. 26, 1947 Clara L. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25th. 19 47, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 46, to Dec. 25 19 47
 and that I last saw him alive on Dec. 25 19 47

Immediate cause of death Coronary Thrombosis
Anterior wall of heart
disease
 Due to _____
 Due to _____
 Other conditions _____

DURATION

(Include pregnancy within 3 months of death)

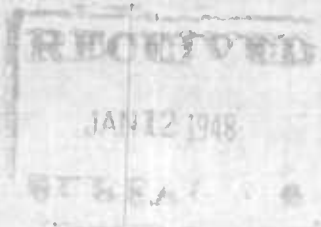
Major findings of operations None Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE A. R. Coppola, M.D. M. D. or other
 Address Chestertown, Maryland Date signed 12-26-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen Anne's
City or town St. Michaels Church Hill Ind.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Virginia County ?
City or town Galax
(If outside city or town limits, write RURAL and give nearest town)
Street No. Galax
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Sarah H. Wooten
4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Thomas Wooten
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) March 11 - 1870

8. AGE: Years 77 Months 9 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name George E. Soins

13. Birthplace Va.

14. Maiden name Elizabeth Redman

15. Birthplace Va.

16. Informant Mrs. James Perkins

Address St. Michaels Church Hill Ind.

17. Burial Date thereof Dec. 14 - 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Quaker

Location Galax Virginia

18. Funeral director Edgar L. Lane

Address Church Hill Ind.

19. 12-13 19 47 Edgar L. Lane
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 47 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 19 47 to Dec 12 19 47

and that I last saw him or alive on Dec 12 1947 19 47

Immediate cause of death _____ DURATION _____

Broncho-Pneumonia 3 days

Due to _____

Due to _____

Other conditions Cerebral hemorrhage
& hemiplegia
(Include pregnancy within 6 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Henry Foster M. D. or other _____

Address Cookeville Ind Date signed 12/13/47

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JAN 10 1948

BUREAU